DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10294

FILED APR 17 1940

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 417

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St.Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St.Joseph's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 days. In this community: Yes (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St.Joseph. (If outside city or town limits write "RURAL")
(d) Street No.: 108 W.Market St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ______ years.

3. (a) PRINT FULL NAME: Laura Ellen Farnan 1.55
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Thomas J.Farnan
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: February 20 1881 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	1	19	hr. ___ min.

9. Birthplace: Nodaway County, Missouri (City, town, or county) (State or foreign country) 6
10. Usual occupation: At Home
11. Industry or business:
FATHER
12. Name: Andrew Nelson 7
13. Birthplace: Unknown (City, town, or county) Denmark (State or foreign country)
MOTHER
14. Maiden name: Rebeca Thompson
15. Birthplace: Nodaway County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Thomas J.Farnan
(b) Address: 108 W.Market Str.St.Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr.11,1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Mount Olivet Cemetery.
18. (a) Signature of funeral director: Herman Wm. Hydenfelder
(b) Address: 1802 Union Str.St.Joseph, Mo.
19. (a) Apr.9,1940 (Date received local registrar) (b) A.J. Nettelbusch [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th year 1940 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from Feb 15, 1940, to April 9, 1940, that I last saw her alive on Apr 8, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Left Hemiplegia	3-21-40
Rt. Hemiplegia	4-7-40
Due to: Hypertension 240/130	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: No	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): no
(b) Date of occurrence: no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? no (e) Means of injury —
23. Signature: [illegible] (M. D. or other)
Address: St. Joseph Mo. Date signed: 3-9-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Albert C. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME Laura Ellen Farman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 5-29-40 (Date received local registrar) (b) W. J. Westbrook (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 9
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Left Hemiplegia	
Due to Hemiplegia	
Due to Hypertension	
Due to # Cerebral hemorrhage	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations $2.00
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Owen W Crane (M. D. or other)
Address St Joseph Date signed

S-10294 1940